

## ***Kansas Medical Assistance Programs***

Provider Line: 1-800-933-6593  
Consumer Line: 1-800-766-9012

P.O. Box 3571, Topeka KS 66601-3571  
Prior Authorization: 1-800-285-4978 or 785-274-5499  
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

### **CHILDREN GROWTH HORMONE RENEWAL REQUEST FORM**

Consumer Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Consumer ID#: \_\_\_\_\_ Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Drug Requested: \_\_\_\_\_ NDC: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Provider Medicaid ID#: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Pediatric Endocrinologist Name: \_\_\_\_\_ Provider Medicaid ID#: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Provider Contact Person: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

**1. Please include History & Physical, growth curve, height velocity and clinical notes within 6 months of request.**

**2. Growth rate over 6 month period (please include 3 measurements in centimeters).**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Height in centimeters \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Height in centimeters \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Height in centimeters \_\_\_\_\_

**3. Is consumer compliant with Growth Hormone therapy?** \_\_\_\_\_

**4. Radiological evidence of open epiphyseal growth plates for boys >16yr age and girls >15 yr age.**

**Signature of Physician or Designee:** \_\_\_\_\_

**Completed form should be faxed to 1-800-913-2229.**

**This form will be returned unprocessed if it is not completed in its entirety.  
Initial prior authorization is for 6 months or at SRS Program Manager's discretion.**